

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031014

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4283

FILED SEP 4 1962

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Kansas City

Length of stay in 1b

43 yrs.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Baptist Memorial Hosp.

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Jackson

c. CITY OR TOWN

Kansas City

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

804 West 70th St.

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

FRANCIS

Middle

HAROLD

Last

GREENE

4. DATE OF DEATH

Month

Day

Year

Aug

19

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐

Widowed ☐ Divorced ☐

Married

8. DATE OF BIRTH

June 17, 1889

9. AGE (last birthday)

73

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HR

Months

Days

Hours

Min.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Stelmach

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause, giving first and last name of disease condition given in PART I (a))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic Heart Disease

Acute Myocardial Infarction

Cardiac Decompensation

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

Unknown

approx 12 hrs

6 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11-11-54 to 8-18-62 and last saw him alive on 8/18/62

Death occurred at 3:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree & title)

W.J. Stelmach MD

22b. ADDRESS

7951 State Line

22c. DATE SIGNED

8/20/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

8-20-62

23c. NAME OF CEMETERY OR CREMATORY

Mt. Moriah Mausoleum

23d. LOCATION (City, town, or county)

Kansas City, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Stine & McClure Kansas City, Mo.

25. DATE RECD. BY LOCAL REG.

8-20-62

26. REGISTRAR'S SIGNATURE

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Dr. W. J. Stillman M.D.
7949 State Line

~~11-4-73~~ 11-4-7367

10:30-12 Today

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.